DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

MENTAL HEALTH PARITY FOCUSED SURVEY

FINAL REPORT

Aetna Health of California, Inc.

Human Affairs International of California

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CONTENTS

EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a Focused Survey of Aetna Health of California, Inc., (the "Plan") and Human Affairs International of California (the "Delegate") from April 25, 2005, to April 28, 2005. A "focused survey" assesses compliance of a particular aspect of plan operations with the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene"). In this case, the Focused Survey assessed compliance of the Plan's delivery of mental health services. (Section 1374.72 of the Health and Safety Code, Severe mental illnesses; serious emotional disturbances of children.) This report presents findings and deficiencies from the Focused Survey.

Aetna Health of California was the third focused survey completed of seven focused surveys scheduled between March and June 2005. Plans that were surveyed are Knox-Keene licensed full service plans and, if applicable, specialty mental health plan delegates that administer and provide mental health benefits and services on behalf of the full service plan.

Health and Safety Code Section 1374.72, often referred to as the "**Parity Act**," requires full-service health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions. Rule 1300.74.72 requires health plans to provide timely access and referral for the diagnosis and treatment of conditions set forth in Section 1374.72. The Rule also requires full-service health plans that contract with specialty mental health plans for the provision of mental health services to monitor the collaboration between the two contracting plans and ensure the continuity and coordination of care provided to enrollees.

The Plan delegates the provision of mental health services to Human Affairs International of California (the "Delegate"). The Delegate provides mental health services to 100% of the Plan's enrollees (See Appendix B).

Background

Aetna Health of California Inc., entered the California marked in 1979 through an acquisition of Foundation Health Plan of San Bernardino, Inc. It was licensed as a full-service health care service plan in the State of California on August 5, 1981. Subsequently, the Plan acquired a series of existing health plans and changed its name with each acquisition as noted below.

- 8/10/79-3/05/81 Foundation Health Plan of San Bernardino, Inc.
- 3/05/81-9/30/87 Inland Health Plan
- 9/30/87-11/30/87 PARTNERS Health Plan of California
- 11/30/87-4/29/91 PARTNERS Health Plan of Southern California, Inc.
- 4/29/91-01/12/93 Aetna Health Plans of Southern California, Inc.
- 1/12/93-12/31/97 Aetna Health Plans of California, Inc.
- 12/31/97-07/10/02 Aetna U.S. Healthcare of California, Inc.
- 07/10/02 Aetna Health of California, Inc.

The Plan is wholly owned by Aetna Health Holdings, LLC. The Plan holds an administrative services agreement with Aetna Health Management, LLC, for the provision of numerous administrative services to the Plan. Aetna Health Holdings, LLC, and Aetna Health Management, LLC, are both subsidiaries of Aetna, Inc.

Human Affairs International, Inc., is a Knox-Keene licensed provider of employee assistance program (EAP) services and risk-based managed behavioral healthcare services. It is a wholly owned subsidiary of Magellan Behavioral Health, Inc., which, in turn, is a wholly owned subsidiary of Magellan Health Services, Inc. Magellan Health Services, Inc., is a publicly traded corporation.

The Delegate was incorporated in 1987 as a subsidiary of Human Affairs International, Inc., to conduct employee assistance program (EAP) and non-capitated managed behavioral health care. One year later, Human Affairs International, Inc., and its subsidiaries were purchased by Aetna Life Insurance Company. In June 1989, the Plan was licensed by the Department of Corporations as a statewide specialty EAP health care service plan under the Knox-Keene Act. In 1997, Magellan Health Services, Inc., acquired the Plan's parent, Human Affairs International, Inc., and its subsidiaries.

At the time of this survey, Plan and Delegate staff members stated that Aetna and Magellan Health Services were in negotiations for Aetna to acquire the three HAI service centers that serve Aetna enrollees, including the El Segundo, CA, HAI service center. Staff members anticipate that the Aetna acquisition will be effective January 1, 2006, at which time Aetna will again have an in-house behavioral health program.

Survey Results

As part of the Focused Survey, the Department assessed the Plan's operations in the following four (4) major areas as they relate to the Parity Act: **Access and Availability of Services, Continuity and Coordination of Care, Utilization Management,** and **Delegation Management**.

The Department identified two (2) compliance deficiencies in the Plan's implementation of and compliance with Section 1374.72. (See Section III, Table 1). One (1) deficiency was found in the area of Access and Availability of Services and one (1) deficiency was found in the area of Utilization Management.

Please refer to Section III for a detailed discussion of the deficiencies, the Department's findings, required corrective actions, the Plan's response and compliance efforts, and the Department's final determination regarding the status of the deficiencies.

SECTION I. FOCUSED SURVEY BACKGROUND

The Department's authority to conduct surveys comes from Knox-Keene, which mandates that the Division of Plan Surveys conduct on-site medical surveys of all licensed health plans at least once every three (3) years, including full-service and specialized plans. Full service health plans are defined as plans that provide all basic health care services. Specialized plans include behavioral health, vision, dental, and chiropractic plans.

In its planning for 2005, the Department's administration directed the Plan Surveys Division to design focused surveys to review health plan compliance with enacted mental health parity laws. The project began in November 2004 and includes three phases:

(1) Stakeholder input, inclusive of several meetings held to gather comments and identify issues currently voiced in the mental health community;
(2) Operations phase, including survey tool development and scheduling; and
(3) Conduct of surveys.

The Department supports continued discussions with stakeholders and will receive comments and suggestions throughout the project.

The purpose behind the focused surveys is to assess specific plan compliance and also to research some of the problems voiced by stakeholders, such as inadequate access to mental health providers and lack of payment of emergency mental health services. Meeting the challenges of implementation of the parity law from the health plan perspective was addressed with Plan management during the first day of the focused survey.

The Focused Survey Approach

The purpose of focused surveys is to afford the Department the ability to swiftly respond to potential serious health plan problems, concerns, or questions raised by consumers, legislators or other Department divisions on a particular issue. Subject matter of focused reviews could include assessment of compliance with newly enacted legislation, such as mental health parity or in some cases, specific applications such as Diabetes supplies regulations.

Although Section 1374.72 is reviewed by the Department for compliance as part of the normal Routine Medical Survey process, this focused survey approach allows a more detailed look at application and compliance.

SECTION II. SCOPE OF WORK

The subject of this Focused Survey is Health and Safety Code Section 1374. 72, Rule 1300.74.72, and other relevant sections of Knox-Keene, including but not limited to:

- Determining whether the plan and its contracted mental health plan have developed and maintained adequate provider networks to promote timely access to mental health services;
- Determining whether the plan and its contracted mental health plan are effectively coordinating the care of enrollees and providing continuity of care; and
- Determining whether the plan and its contracted mental health plans are authorizing and providing medically necessary services mandated under Section 1374.72 in an appropriate and timely manner.

Specifically, the Department assessed the Plan's operations in the following four (4) major areas as they relate to the Parity Act:

- **Access and Availability of Services** – to determine whether the Plan designs benefits for parity diagnoses under the same terms and conditions applied to other medical conditions, whether the Plan clearly communicates those terms and conditions to enrollees, and whether the Plan has developed and maintained adequate provider networks to assure enrollees timely access and referral to mental health services.
- **Continuity and Coordination of Care** – to determine whether the Plan provides appropriate continuity and coordination of care for enrollees with parity diagnoses.
- **Utilization Management/Benefit Coverage** – to determine whether the Plan appropriately authorizes and provides medically necessary treatment and services required under Section 1374.72 to enrollees with parity diagnoses.
- **Delegation Management** - when applicable, to determine whether the Plan adequately and appropriately oversees its contracted specialty mental health plan and ensures that parity mental health services are provided to enrollees with parity conditions in a timely and appropriate fashion, under the same terms and conditions applied to medical conditions.

SECTION III. SURVEY FINDINGS

The table below lists deficiencies identified during the Focused Survey. The Department issued a Preliminary Report to the Plan regarding these deficiencies. In the Report, the Plan was instructed to: (a) develop and implement a corrective action plan for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

TABLE 1: DEFICIENCIES

#	SUMMARY OF DEFICIENCIES	Status
ACCESS AND AVAILABILITY OF SERVICES		
1	**The Plan does not ensure that providers' provisions for after-hour services are reasonable and that providers respond to enrollee messages in a timely manner.** [Rule 1300.67.2(b) and Rule 1300.74.72(f)]	Not Corrected **REMEDIAL ACTION**
UTILIZATION MANAGEMENT		
2	**For benefit denials, the Plan does not clearly describe in the denial letter the provisions in the Evidence of Coverage that exclude coverage of the requested service.** [Section 1367.01(h)(4)]	Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: **The Plan does not ensure that providers' provisions for after-hour services are reasonable and that providers respond to enrollee messages in a timely manner.** [Rule 1300.67.2(b) and Rule 1300.74.72(f)]

Documents Reviewed:

- Contract with individual providers
- Contract with PsyCare Associates, Inc.
- Contract with College Health IPA

Department Findings: Through a 24-hour toll-free telephone service, the Plan's Delegate provides access 24-hours-a-day/365-days-a-year to Member Services personnel and clinical personnel. By means of this telephone service, the Delegate provides enrollees with referrals for appointments, initial authorizations for services, crisis intervention, responses to questions about coverage and benefits and, if necessary, arrangements for emergency care or hospitalization.

The Delegate's contract with individual providers and its two behavioral health provider groups, PsyCare Associates, Inc., and College Health IPA, requires that the provider "maintain reasonable hours of operations and shall make reasonable provision for after-hours services and when the Provider is unavailable." However, neither the Plan nor the Delegate have formally established and promulgated standards for "reasonable provision of after-hours care." Additionally, the Delegate does not currently have a system to monitor the appropriateness of providers' after-hours services arrangements.

This deficiency impacts not only provision of after-hours services, but also coverage and services during normal business hours. Because many mental health practitioners operate in solo practices, they are often not available to answer the phone even during normal business hours (e.g., during counseling sessions). An enrollee desiring to contact a provider (either for an initial appointment or as a continuing patient) will, therefore, often reach the same answering machine message or answering service that the provider uses for after-hours coverage. Thus, for both after-hours and during business hours, the Plan must ensure that provisions for service availability are reasonable.

The Department surveyed 40 providers by telephone during normal business hours to assess provider responsiveness, appointment availability and whether the practice was open to new patients. If the provider or provider staff did not answer the call, the Department assessed: (a) whether an answering machine message or service was in place, and (b) whether the message contained a pager number or answering service by which the enrollee could reach the provider and (c) whether there were instructions to contact 911 if there was an emergency. If the initial call was not answered by the provider of provider office staff, the Department also left a message requesting a return call and monitored whether a return call was received within 24 hours. Fourteen (14) calls were answered by the provider or provider office staff. Of the 27 providers with whom messages were left, 14 responded with a return call within 24 hours, resulting in 28 completed calls (68%).

The Department found that, of the 27 calls that were not answered by the provider or provider staff, all were answered by an answering machine. Seven (7) of the answering machine messages contained instructions regarding the use of 911 for emergencies. All seven (7) of these messages and nine (9) additional messages contained other instructions regarding emergencies or after-hours contact methods (e.g., provider pager number, crisis line referrals).

The Department also performed a telephone survey of 20 providers after normal business hours to assess the presence and content of answering service/machine messages. Eighteen (18) calls were answered by answering machines; one call was answered by a fax machine; and the remaining line was busy for all three attempts at making contact. Of the 18 answered by machines, five (5) directed patients to call 911 for emergencies. Four (4) of these messages and seven (7) additional messages contained other instructions regarding emergencies or after-hours contact methods (e.g., provider pager number, crisis line referrals).

Table 2 summarizes these findings.

TABLE 2: TELEPHONE SURVEY OF PROVIDERS

TOTAL CALLS					If Not Answered By Provider/Staff (Business Hours: N=27 After-hours: N=18)				If Contact With Provider Or Office Staff (N = 28)	
						If Answering Machine:				
Sample Type and Size	Answered by Provider or Office Staff	Not Answered by Provider or Office Staff	Call Back within 24 Hours	Total Contacts with Provider or Office Staff	Answering Machine (M) or Answering Service (S)	Directed Enrollee to 911	Additional Emergency Instructions (e.g., pager, crisis line, crisis center)	Total with 911 and/or Other Emergency Instruct-ions	Open to new patients	Meets Plan's Routine Appointment Availability Standard of 10 Working Days N=21
Calls during business hours N=41	14 (34%)	27 (66%)	14 (34%)	28 (68%)	M=23 (85%) S=4 (15%)	7 (30%)	16 (70%)	16 (70%)	21 (75%)	20 (95%)
Calls after hours N= 20	(0%)	20 (100%)	N/A	N/A	M=18* (90%)	5 (28%)	11 (61%)	12 (67%)	N/A	N/A

*Two calls were not completed; one was a fax number and one had a busy signal for all three attempts.

Implications: Although an enrollee may initially contact the 24-hour line to arrange for services and may contact the Delegate at any time to arrange for emergency care, once an enrollee has established a counseling relationship with a provider, that enrollee may attempt to contact the provider prior to or instead of contacting the Delegate in an emergency or urgent situation. For this reason, access to individual providers after hours must be ensured and/or clear instructions provided via provider messaging systems regarding how patients may contact the provider and/or other sources of assistance. Additionally, in order to facilitate: (a) prompt handling of current patient's needs, and (b) expeditious responses to calls for new appointments, the Plan must ensure that providers respond in a timely manner to messages left by enrollees.

Corrective Actions: In working with the Delegate, the Plan will establish standards for "reasonable provision of after-hours care." The Delegate will develop a system to monitor adherence to standards to evaluate the adequacy of providers' after-hours services arrangements.

The Plan shall provide evidence that its Delegate has developed and distributed to its providers clear and detailed instructions regarding its requirements for after-hours coverage and messaging.

The Plan shall also provide evidence that a system has been established for monitoring the presence and content of provider answering system messages and for monitoring the timeliness of providers' responses to messages left by enrollees.

Plan's Compliance Effort: The Plan stated that it respectfully disagrees with this finding on the basis that the Department reviewed and approved its Delegate's provider contracts in 2004 and 2005 with respect to after-hours access. Specifically, on 4/29/04, Human Affairs International of California, Inc. filed its Unified individual, group, and facility agreements (Filings 20040014, 20049318; Transaction ID 1083270956015), with no comments received. On 12/28/04, HAI-CA

filed its Unified capitated group agreement (Filing 20042447; Transaction ID 1104252070562) and received the Department's approval on 1/24/05. In each of these agreements, Section 2.3.1 states that the provider "shall maintain reasonable hours of operation and shall make reasonable provision for after-hours services and for when [provider is] unavailable".

The Plan also stated that it respectfully disagrees with this finding on the basis that the Department acknowledged that the regulations are vague regarding requirements for the provision of after-hours services in its Follow-Up Report of the Routine Medical Survey of Behavioral Health Plan for Merit Behavioral Care of California, Inc. dated 02/02/05. In that report Merit Behavioral Care of California, Inc. stated:

> "The Department's deficiency finding that the Plan does not set expectations for contracting providers to devote a minimum number of hours to enrollees is not based on any properly established legal requirements. There is no provision in the Act or in regulations promulgated by the Department that mandates plans to require contracting providers to dedicate a minimum number of hours to serving their enrollees. The Plan has implemented processes that are reasonably calculated to meet the requirement of §1300.67.2(b) that the "hours of operation...shall be reasonable".
>
> The Department's deficiency finding that the Plan does not adequately provide for after-hours services is not well-founded. The Plan maintains access 24 hours a day, 7 days a week through its call center and, after normal business hours, the call center of its parent, Magellan Behavioral Health. Each call center is staffed at all times by licensed mental health professionals who are fully capable of responding to urgent after-hours concerns of enrollees and contacting contracted providers as appropriate and/or referring enrollees with emergencies to appropriate emergency facilities in their local communities. In addition, in accordance with §1300.51(I)(e) of the rules, the Plan solicits from each non-physician contracting provider his/her hours of operation and the provision made for after-hours service. Given the around-the-clock accessibility of call center clinicians, the Plan's provisions for after-hours services are reasonable and meet the requirements of §1300.67.2(b).
>
> In that report, the Department stated:
> Department's Findings Concerning Plan's Subsequent Compliance Efforts: As a result of the Department's legal review, the contractual requirement for participating providers to specify the minimum number of hours per week or the requirements for provision for after-hours services is not applicable due to the vagueness of the regulation. The Plan has implemented processes meet [sic] the requirement pursuant to 1300.67.2(b) that the hours of operation and provision for after-hours services shall be reasonable.
> STATUS: Corrected."

Finally, the Plan stated that, as part of its ongoing operations to integrate behavioral health, the Plan will file new provider contracts shortly with a planned effective date for this new contract language of 1/1/2006.

The Behavioral Health Provider Participation Criteria Schedule specifies the Plan's requirements regarding access to after-hours services (excerpts as follows):

D. Availability of Services and Coverage

(a). When applicable to the relevant Specialty or Provider Services provided, as determined by Company in its sole discretion, Provider shall: (i) ensure that twenty-four (24) hours-a-day coverage for Members is arranged with another provider participating with Company, except as otherwise provided in subsection (b) of this section, and (ii) have a reliable twenty-four (24) hours, seven (7) days-a-week answering service or machine with a beeper or paging system. A recorded message or answering service which refers Members to the emergency room is not acceptable. For outpatient services, the covering provider's office must be within twenty-five (25) minutes non-rush hour travel time from the office of the covered provider.

(b). Provider must submit for prior approval by Company any coverage arrangements made with a nonparticipating provider.

The Behavioral Health Specialist Physician Participation Criteria Schedule specifies the Plan's requirements regarding access to after-hours services (excerpts as follows):

C. Coverage

1. When applicable to the relevant Specialty, as determined by Company in its sole discretion, Specialist Physician shall ensure that twenty-four (24) hours-a-day coverage for Members is arranged with another Company Participating Specialist Physician, except as otherwise provided in subsection 3 of this section.
2. For outpatient services, the covering physician's office must be within sixty (60) minutes non--rush hour travel time from the office of the covered physician.
3. A Specialist Physician must submit for prior approval by Company any coverage arrangements made with a nonparticipating specialist physician.

The Plan submitted the following documents:

- Sample section from draft Behavioral Health Provider Participation Criteria Schedule
- Sample section from draft Behavioral Specialist Physician Participation Criteria Schedule

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that this deficiency has not been corrected.

The Department notes that its findings as stated in the Follow-up Report for Merit Behavioral Care of California, Inc., dated 02/02/02 are neither directly related nor comparable to the deficiency found during this Mental Health Parity Focused Survey.

In that report, the Plan stated, "The Plan's regulated business is limited to Employee Assistance Programs, which are not designed to provide emergency treatment." Emergency treatment and after hours provider availability, by contrast, are required when a behavioral health plan or its delegate provides services to enrollees who have been diagnosed with a mental health parity condition, for example, severe mental illness or serious emotional disturbances of children.

Likewise, what constitutes "reasonable" after-hours arrangements for Merit's EAP line of business would not be sufficient for enrollees with parity conditions. This fundamental difference between an EAP program and a managed health behavioral program that deals with parity conditions makes it critical for the Plan to ensure that providers' provisions for after-hour services are reasonable and that providers respond to enrollee messages in a timely manner.

In addition, the Department notes that the deficiency found during the 2002 Merit survey focused on the lack of specific requirements within the Plan's provider contracts. In contrast, the deficiency found during the current mental health parity survey was not related to the Plan's failure to include after-hours and messaging standards in its provider contracts as such standards could reasonably be established and conveyed through alternate means (e.g., Provider Manual, policies and procedures). The Department's finding in this survey was that the Plan did not ensure the actual provision of after-hours services and timely responses to enrollee messages through an overall monitoring effort which includes: (a) establishing standards which are reasonable for the needs of its patient population against which it will measure provider performance, and (b) monitoring its providers to evaluate the adequacy of their after-hours services arrangements and responses to messages left by enrollees. Although enrollees may have no difficulty accessing the Plan's after-hours service line, access to their own treating providers was inadequate as evidenced by the results of the Department's telephone survey.

The Department reviewed the submitted draft documents with proposed contract changes scheduled for implementation on January 1, 2006. The Department finds that the proposed Behavioral Health Provider Participation Criteria Schedule establishes acceptable standards by including provider contract provisions requiring "24-hour coverage" and "an answering service or machine with a beeper or paging system." The proposed changes to the Specialist contract mention 24-hour coverage, however, they do not include information on the arrangements the Plan requires for contacting the provider. If the Plan does not include this specific information in the provider contract itself, it needs to be communicated to providers through other approaches (e.g., Provider Manual).

The Department finds that the Plan's response did not address the need to conduct monitoring of the presence and content of provider after-hours arrangements and of the timeliness of providers' responses to messages left by enrollees.

REMEDIAL ACTION: Within forty-five days of receipt of this Final Report, the Plan shall submit to the Department a corrective action plan, including timeframes, to **(a)** develop and distribute to its providers clear and detailed instructions regarding its requirements for after-hours coverage and messaging, **(b)** establish and implement a system for monitoring the presence and content of provider answering system messages and for monitoring the timeliness of providers' responses to messages left by enrollees, and **(c)** address any deficiencies found in provider performance.

At the time of the Plan's next Routine Medical Survey, which at this report date is scheduled to occur in February 2006, the Department will review the Plan's implementation of the corrective actions and its effectiveness in ensuring that enrollees can reach and receive response from providers in a timely manner.

B. UTILIZATION MANAGEMENT

Deficiency 2: For benefit denials, the Plan does not clearly describe in the denial letter the provisions in the Evidence of Coverage that exclude coverage of the requested service. [Section 1367.01(h)(4)]

Documents Reviewed:

- 10 parity diagnosis denial files

Department Findings: Of the ten (10) parity benefit denials that the Department reviewed, none of the files, or zero percent, clearly specified the provisions in the contract that excluded the denied request. In the denial letters, the Delegate refers to areas in the Evidence of Coverage (EOC), Plan Benefit Certificate, and the Summary of Coverage (SOC) in general, e.g., Limitations & Exclusions Section. However, the denial letters did not cite the specific benefit limitation or exclusion or otherwise clearly and concisely describe the reason for the denial. In some cases, the denied benefit is not found in the referenced Limitations and Exclusions Section. Table 3 summarizes these findings.

TABLE 3: BENEFIT DENIALS

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# (%) COMPLIANT	# (%) DEFICIENT
Benefit Denials	10	The reason for the benefit denial accurately reflects the provisions of the relevant Evidence of Coverage.	0	10

Implications: Because the Delegate's benefit denial letters do not reference the relevant limitation and/or exclusion in the member's legal document (e.g., EOC or SOC), there is limited full and fair disclosure of the reasons for denying the service on the basis of a benefit exclusion or limitation.

Corrective Action: The Plan shall require its Delegate to take the following actions to correct its benefit denial letters:

- Create a benefit denial template letter for those services that are denied on the basis of benefit coverage exclusions or limitations.
- The Plan will provide evidence that letters have been changed and consistently cite the pertinent section of the EOC; clearly describing the benefit limit or exclusion in relation to the requested service.
- The Plan shall require the Delegate to audit its benefit denials quarterly and report the results of the audit and any indicated corrective action to the Plan.

Plan's Compliance Effort: The Plan respectfully disagreed with parts of this finding and the Department's interpretation of the regulations involving benefit denials.

The Plan stated that they, along with their Delegate use the Industry Collaborative Effort (ICE) Pre-Service Denial Notice (which was attached as evidence with their response to the Preliminary Report), which was approved by ICE in August 2004.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been corrected.

To ensure that Plan enrollees receive clear and concise explanations in their utilization management denials communications, the Plan is directed to monitor communications of these denial correspondences to ensure clear, concise and meaningful explanations are communicated to plan enrollees as required in Section 1367.01(h)(4). Providing the enrollee with a clear explanation can occur in a number of ways including, (1) citing specific benefit language and/or pertinent sections of the EOC or other member materials, and (2) including a clear and concise narrative description of why the benefit is being denied including disclosure of the criteria or guidelines utilized by the plan in making its medical necessity determination.

At the time of the Plan's next Routine Medical Survey, which at this report date is scheduled to occur in February 2006, the Department will review the Plan's efforts to monitor communications of the denial correspondences to ensure clear, concise and meaningful explanations are communicated to plan enrollees as required in Section 1367.01(h)(4).

Finally, the Department has and continues to work collaboratively with ICE on a variety of issues, including template versions of statutorily required letters. However, the Department does not formally approve or disapprove of ICE templates. The Plan had stated in their response that the Department had approved the ICE Pre-Service Denial Notice in 2004.

C. SURVEY CONCLUSIONS

The Department has completed its Focused Survey of the Plan. The Department will continue to monitor the Plan's compliance with the provisions of the Parity Act through its Routine Medical Surveys, which are conducted at least once every three (3) years.

The Department will develop a Summary Report that aggregates and analyzes the Parity Focused Survey results of all plans surveyed by Fall 2005. The Summary Report will be available to the plans and to the public through the Department's Public File.

A P P E N D I X A

METHODOLOGY & PARAMETERS

A. Review Methodology

The Department conducted a Focused Survey of the Plan from April 25 to April 29, 2005, at the Delegate's offices in El Segundo, California, to evaluate the Plan's compliance with Section 1374.72. The Department conducted the survey utilizing the clinical expertise of three licensed health professionals, including two board-certified psychiatrists and a psychiatric nurse specialist.

Survey activities included the review of plan documents, enrollee case files, and claims. The Surveyors conducted interviews with officers and staff from the Plan and its Delegate. Surveyors also telephoned 50 participating providers to assess appointment availability and evaluate the providers' after-hours telephone message in regard to the provision of emergency services. Each survey activity is described in greater detail below.

Review of Plan documents – The Department reviewed a number of additional materials to assess various aspects of Plan compliance, for example:

- Policies and procedures for all related activities
- Internal performance standards and performance reports
- Communications regarding benefits
  - Explanation of coverage
  - Explanation of benefits
- Materials demonstrating continuity and coordination of care
  - Reports on inpatient admissions, office visits and other services provided
  - Clinical practice guidelines and protocols
  - Case management program descriptions and case files
- Reports on access and availability of services
  - Number and geographic distribution of clinicians, facilities and programs
  - Appointment availability
  - Timeliness of answering the triage and referral telephones
- Reports demonstrating the Plan's oversight of any activities performed by its Delegate

Review of enrollee files: Prior to the on-site visit, the Department requested logs for a number of Plan activities; e.g., utilization review, claims processing, case management, etc. From these, the Department selected samples of case files for a comprehensive review. Review focused on measures such as appropriateness of denials of services, timeliness of decision-making, and coordination of care, as well as the appropriate exchange of information among providers.

The review of utilization management files was performed with the participation of Plan staff. Table 4 below displays the categories of utilization management files reviewed and the sample sizes selected.

TABLE 4: FILES REVIEWED

CATEGORY OF FILE	SAMPLE SIZE
Utilization Management – Medical Necessity Denials for Children with Autism or Seriously Emotionally Disturbed Children	10
Utilization Management – Medical Necessity Denials for Other Individuals with Parity Diagnoses	12
Utilization Management – Benefit Denials for Children with Autism or Seriously Emotionally Disturbed Children	7
Utilization Management – Benefit Denials for Other Individuals with Parity Diagnoses	3
Utilization Management – Denials of Pharmaceuticals to Treat Parity Diagnoses	9
Continuity and Coordination of Care – Case Management Files	20

Review of claims – Prior to the on-site visit, the Department requested claims listings. From these, the Department selected samples of claims for comprehensive review. Review focused on measures such as the appropriateness of denial and the accuracy of payment based on mandated parity benefits. The review of claims files was performed with the participation of Plan staff. Table 5 below displays the categories of claims reviewed and the sample sizes selected.

TABLE 5: CLAIMS FILES REVIEWED

CATEGORY OF CLAIM	SAMPLE SIZE
Claims for emergency services from non-participating providers	18
Claims for emergency services from participating providers	25

Interviews – The Department interviewed staff from both the Plan and Delegate to augment the review of documents and obtain a comprehensive picture of Plan activities surrounding the implementation of Section 1374.72, as well as to discuss the specific files, claims and documents the Department reviewed. The list of individual officers and staff members interviewed, along with their respective titles, may be found in Appendix C. The list of the Department's survey team members that conducted the interviews may be found in Appendix D.

B. Utilization Management File Review Parameters

The parameters assessed during the review of each file included (as appropriate to each sample type):

- Diagnoses
- Accuracy of case categorization (parity vs. non-parity)
- Decision rendered/action taken by plan (approval or denial)
- Adequacy of clinical information obtained to support decision-making
- Documentation of rationale supporting the decision rendered
- Accuracy of decision based upon statutory requirements and
- Consistency between decision and communication sent to the affected practitioner/provider and member

C. Claims Review Parameters

The parameters assessed during the review of claims included:

- Diagnoses
- Accuracy of claim categorization (parity vs. non-parity; participating vs. non-participating; and emergency vs. non-emergency)
- Adequacy of administrative and clinical information obtained to support denial decision-making
- Appropriateness of denial
- Documentation of referral to medical review prior to denial decision rendered
- Accuracy of documented denial reason based upon plan policies regarding claim processing
- Accuracy of payment based on mandated parity benefits and
- Appropriateness and accuracy of communication sent to the affected practitioner/provider and enrollee

A P P E N D I X B

OVERVIEW OF PLAN OPERATIONS

A. Plan Profile

Tables 6 through 8 below summarize the information submitted to the Department by the Plan and its Delegate in response to the Pre-Survey Questionnaire:

TABLE 6: PLAN PROFILE

Type of Plan	**Full Service Plan**	
Specialized Health Care Service Plan(s) or Mental Health Plan(s) (i.e., delegates) with which the Plan Contracts for Provision of 1374.72 Services as of December 31, 2004	**Knox-Keene Licensed Behavioral Health Plan**	**Enrollees**
	Human Affairs International, Inc.	277,482
Specialty IPAs/Medical Groups with which the Plan (i.e., subdelegates) Contracts for the Provision of 1374.72 Services as of December 30, 2004	**IPA/Medical Group**	**Enrollees**
	PsyCare Associates, Inc.	38,982
	College Health IPA	187,722
	Total	226,704
Number of Enrollees Covered by Mental Health Parity as December 31, 2004	**Products**	**Enrollees**
	HMO	266,534
	QPOS	7,545
	USAccess POS	3,403
	Total	**277,482**

Service Area(s) *(Counties, in full or in part)*	Alameda Contra Costa Kern Los Angeles Marin	San Joaquin Santa Clara Orange Riverside San Bernardino	San Diego San Francisco San Luis Obispo San Mateo	Santa Barbara Santa Cruz Solano Stanislaus Ventura

Plan Identification of Enrollees Eligible for Parity Services
Adults: Adults that have parity diagnoses are identified through the diagnoses on claims. The claims system has edits that contain the ICD-9-CM codes for the parity diagnoses to identify those services that fall under the parity benefit.
Seriously Emotionally Disturbed (SED) Children: The Delegate considers any child that has a DSM-IV diagnosis, other than for substance abuse or developmental disorders, to be seriously emotionally disturbed. The Delegate identifies these SED children through claims review.

TABLE 7: MENTAL HEALTH PROVIDER NETWORK

Practitioners that Treat Adults	Number in the Network
Psychiatrists	387
Doctoral-level psychologists	953
Mental health nurse practitioners	1
MFTs	1297
LCSWs	662
Total	3300

Practitioners that Treat Children and Adolescents	Number in the Network
Psychiatrists	229
Doctoral-level psychologists	746
Mental health nurse practitioners with furnishing numbers	0
Mental health nurse practitioners	1
MFTs	1115
LCSWs	556
Total	2647

Programs and Institutional Providers that Treat Adults	Number in the Network
Acute inpatient units—voluntary admissions	51 Free-standing Psychiatric Facilities
Acute inpatient units—involuntary admissions	51 Free-standing Psychiatric Facilities[1]
Crisis treatment centers/programs	N/A
Intensive outpatient treatment programs/partial hospitalization	32 Intensive Outpatient Programs 28 Partial Hospitalization Facility Programs
Residential treatment programs	3 Residential Treatment Programs
Eating disorder programs	9 Partial Hospitalization Programs 12 Intensive Outpatient Programs 1 Residential Treatment Program 5 Inpatient Hospitals

[1] The Delegate contracts only with free-standing psychiatric facilities that accept both voluntary and involuntary admissions.

Programs and Institutional Providers that Treat Children and Adolescents	Number in the Network
Acute inpatient units—voluntary admissions	23 Psychiatric Facilities.
Acute inpatient units—involuntary admissions	See footnote[1]
Crisis treatment centers/programs	N/A
Intensive outpatient treatment programs/partial hospitalization	18 Intensive Outpatient Programs, 21 Partial Hospitalization Facility Programs
Residential treatment programs	9 Residential Treatment Programs
Eating disorder programs	5 Partial Hospitalization Programs 7 Intensive Outpatient Programs 3 Residential Treatment Program. 1 Hospital Eating Disorder Program

TABLE 8: ACCESS AND AVAILABILITY STANDARDS

Type of Practitioner	Ratio of Practitioners to Enrollees	Geographic Availability	Percent of Open Practices
Psychiatrists	Minimum number of individual behavioral health practitioners is 1.0 per 1,000 members	1 MD in 10 miles (Urban/Suburban) 1 MD in 40 miles (Rural)	No standard and no routine monitoring
Doctoral-level psychologists		1 Non-MD in 10 miles (Urban/Suburban) 1 Non-MD in 40 miles (Rural)	
Master's prepared therapists			

Appointment Availability Standards	
Type of Services	**Standard**
Non-life-threatening Emergency	95% percent of appointments within 6 hours
Urgent Care	95% of appointments within 48 hours
Initial Post-hospitalization Follow-up Visit	Appointment within 7 calendar days of discharge
Routine Visit	85% of appointments within 10 days

Telephone Responsiveness Standards	
Telephone Availability	**Standard**
Triage and Referral	Telephone callers must reach a non-recorded voice within 30 seconds
Triage and Referral Abandonment Rate	Telephone caller abandonment rates should not exceed five percent
Member Services Average Speed of Answer	Telephone callers must reach a non-recorded voice within 30 seconds
Member Services Abandonment Rate	Telephone caller abandonment rates should not exceed five percent

B. Overview of Programs

Table 9 below presents a brief overview of the Plan's operations in each of the four program areas that were examined during the Department's focused survey.

TABLE 9: OVERVIEW OF PROGRAMS

PROGRAM	DESCRIPTION
ACCESS AND AVAILABILITY	• The Plan's Evidence of Coverage accurately describes the benefits for parity diagnoses and non-parity diagnoses. However, the text does not define "serious mental illness" or "serious emotional disturbances of a child" in the section that describes the benefits nor does it direct the reader to the glossary at the back of the EOC where these terms are defined. • The Delegate contracts with PsychCare and Associates, Inc., (a Subdelegate) to provide all professional mental health services in San Diego County and with College Health IPA (a Subdelegate) for provision of services in a five-county area around Los Angeles. This accounts for 82% of the Plan's enrollment. The Plan contracts directly with providers in all other parts of the service area. • The enrollee can access a master's-level therapist or psychiatrist directly for an initial course of treatment (see below) or can call the Delegate's customer services department to obtain a referral to a therapist or psychiatrist. • The Delegate delegates screening and triage and utilization management to the Subdelegates. Enrollees that call the Delegate's 800 number for screening and triage are "warm" transferred to the Subdelegate, with the Delegate customer service staff member staying on the line until the Subdelegate staff person answers. • The Delegate permits open access to the first eight (8) ambulatory behavioral health visits for therapy and the first 12 behavioral health visits to a psychiatrist for medication evaluation and management. Beyond these visit limits the Delegate requires the requesting practitioner to submit a Treatment Request Form (TRF). Based on review of clinical information in the TRF, the Delegate prior-authorizes further services. • The Delegate monitors its network against the network availability standards shown in Table 9 above and reports its results internally to the Plan. • The Delegate does not have standards for the percent of practices that are accepting new patients ("open practices"). However, the Delegate has a Web-based mechanism by which providers can temporarily or permanently close their practices to new patients.

ACCESS AND AVAILABILITY *(continued)*	• The Delegate has established the appointment availability standards shown in Table 9 above. The Delegate monitors appointment availability by comparing the date that the enrollee called for authorization for a routine appointment with the date of appointment. The Delegate reports the availability of appointments on an annual basis. The results that the Delegate reported for April 2004 were: ▪ Emergent Life-threatening: 96% within the required timeframe ▪ Emergent Non Life-threatening: 93% within the required timeframe ▪ Urgent: 96% within the required timeframe ▪ Routine: 99% within the required timeframe • The Delegate measures post-hospitalization follow-up on a concurrent basis. The most recent data at the time of the survey was that 83% of enrollees were seen within 7 days of discharge and 86% were seen within 30 days of discharge. To improve performance in this area, the Delegate has undertaken two strategies: 1) creation of additional capacity in northern California contracts through contracting with psychiatrists for guaranteed appointment slots and 2) establishing a system for case managers to remind enrollees to keep their post-discharge appointments.
UTILIZATION MANAGEMENT	• In addition to therapy and medication-management sessions, certain ambulatory services and procedures must be prior-authorized. These include biofeedback, outpatient electroconvulsive therapy (ECT), hypnosis, and psychological testing. • All inpatient admissions require prior-authorization, except for emergent admissions. Continued inpatient stays require ongoing intermittent, concurrent authorization. The Delegate uses a proprietary, criteria-based instrument, called the Level of Care Assessment Tool (LOCAT), to assist in making decisions regarding the appropriate level of inpatient care. • The Delegate considers all children under the age of 18 that seek evaluative, therapy, and inpatient services for mental health conditions other than developmental delay or chemical dependency, to qualify for parity mental health services. • The Delegate provides comprehensive evaluative, diagnostic, and therapeutic services for children with autism and pervasive developmental delay, with the exception of physical and occupational therapy, which are the responsibility of the Plan and its delegated medical IPAs and medical groups. • The Delegate coordinates services with the Regional Centers when possible, but does not require enrollees to receive evaluative or treatment services from the Regional Center. The autism case manager refers families with children with autism or pervasive developmental delay to their respective Regional Centers so that they can take advantage of supplemental services, such as family support groups and education programs on autism research and services.

CONTINUITY AND COORDINATION OF CARE	• The Delegate encourages communication between mental health providers and primary care providers by including an easy to complete PCP communication form in all "Notification of Authorization" (NOA) forms sent to providers. • The Delegate conducts annual reviews of treatment records of high-volume mental health providers, which includes a review of the documentation of the provider's communication with enrollees' primary care physician (PCP). • The Delegate's audit of Delegate care manager files includes a review of documentation that the care manager encouraged the attending physician to coordinate care with the enrollee's PCP and with other behavioral health providers. • The Delegate has established four care management processes to foster continuity and coordination of care: general care management; intensive care management; med-psych care management for enrollees that have both medical and mental health conditions; and depression care management. A review of five files from each type of care management demonstrated consistently strong continuity of contact with members and providers and consistent efforts to facilitate communication among various mental health and medical providers. • There is a Delegate care manager co-located with the Plan care managers to facilitate co-management. Additionally, there is a monthly med-psych care management case conference that involves both the Plan and Delegate care managers and medical directors in reviewing care for enrollees with complex care needs. • In addition to the care management programs, the Plan and Delegate have established four Plan-level "Med/Psych Programs" in order to assist medical providers in the identification and referral of members with psychiatric conditions. These are: ▪ The Trigger Diagnosis Program, in which enrollees that are admitted to medical beds are screened if they are admitted with one of eight (8) diagnoses, which include overdose, suicide attempt, change in mental status, substance withdrawal syndromes, dementia, and eating disorders. This program requires the Delegate's care manager to make an outreach contact with the members so identified. ▪ Depression in Primary Care, which is the Plan's program to educate PCP's regarding psychiatric diagnosis and referral. ▪ Moms-to-Babies Early Intervention, which provides pregnant members with education and self-screening tools and post-partum depression. ▪ Coexisting Medical Illness, which is also an educational outreach program for medical providers, and provides the depression screening and referral components for the Plan's disease management programs for asthma, diabetes, coronary artery disease, congestive heart failure and low-back pain. Enrollees that complete the referral to the Delegate are entered into the med-psych care management program.

CONTINUITY AND COORDINATION OF CARE ***(Continued)***	• The Delegate has promulgated three clinical practice guidelines relevant to parity diagnoses: schizophrenia, depression, and suicide risk. These are based largely on the American Psychiatric Association guidelines. In addition, the Delegate provides "clinical monographs" as a supplement to these guidelines, representing reviews of disease literature. • The Plan and Delegate have developed and implemented a depression education program that is presented by Delegate clinical staff at PCP offices. In 2004, the Delegate provided education sessions to 50 PCP offices. • The Plan does not delegate complaint management. The Plan presented documentation that there was a total of 100 complaints about behavioral health in the 12-month period prior to the survey and none of them were related to parity benefits or services related to parity conditions.
DELEGATION	• The contract between the Plan and the Delegate, including amendments and references, addresses all the areas required by the parity mental health legislation. • The Plan Regional Behavioral Health Oversight and Advisory Committee and the Regional Management Delegation Committees oversee the Plan—Delegate relationship. These committees meet on a regular basis. Review of minutes of these two committees for 2004 revealed that the committees regularly address issues relevant to the oversight of the agreement. • The Delegate Prevention and Medical Integration Subcommittee of the Delegate Quality Improvement Committee is the venue for collaborative management between the Plan and Delegate. This Subcommittee is composed of Plan, Delegate and contracted practitioner representatives. • The Plan audits the Delegate on not less than an annual basis against the contractual agreement. The most recent audit was conducted October 12 through the 13, 2004. Review of the findings of this report revealed a 97.5% compliance with "key performance measures." There were no open, uncorrected areas from the previous annual report.

A P P E N D I X C

LIST OF STAFF INTERVIEWED

The following are the key Plan officers and staff who participated in the on-site survey at the Plan's administrative office on April 25 to April 28, 2005.

AETNA HEALTH OF CALIFORNIA, INC.	
Name	**Title**
Jesse Brennan-Cooke, MA, LMFT	Regional BH Manager
Reina Galanes	Compliance Manager
Phyllis Brooks	Pharmacy Services Manager

HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA	
Name	**Title**
Flora Vivaldo, MSW	Plan President and General Manager
Bill Gillis, Psy.D.	Vice President, Clinical Services
Greg Miller, MD	Medical Director
Kevin Reilly Ph.D.	Director of Customer Service
John Vieira	Chief Financial Officer
Chiohko Owens	Claims Supervisor
Erin Kafieh	Clinical Manager
Jaymi Wiley	Network Coordinator
Nadine Duarte	Facility Contracting Manager
Jodi Stevenson	Director of Network Management
Tom Warner, MFT	Care Manager
Hilary Beeby, MFT	Care Manager
Mike Ames, LCSW	Care Manager
Patricia Waldhanz, MSN	Quality Director

A P P E N D I X D

LIST OF SURVEYORS

The Department's Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Name	**Title**
Andrew George	Counsel, HMO Help Center
Dan McCord, MBA	Senior Health Care Service Plan Analyst

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Name	**Title**
Rose Leidl, RN	Contract Manager
Bernice Young	Program Director
Ruth Martin, MPH, MBA	Parity Survey Team Leader
Marshall Lewis, MD	Continuity and Coordination of Care
Erick Davis, MD, MPH, MBA	Utilization Management/Delegation Management Surveyor
Beverly McGuffin, RN, MS, CPRP	Access and Availability Surveyor
Linda Woodall	ER Claims Surveyor

A P P E N D I X E

STATUTES AND REGULATIONS APPLICABLE TO THE IDENTIFIED DEFICIENCES

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan does not ensure that providers' provisions for after-hour services are reasonable and that providers respond to enrollee messages in a timely manner. [Rule 1300.67.2(b) and Rule 1300.74.72(f)]

Citations:
Rule 1300.67.2(b)
Hours of operation and provision for after-hour services shall be reasonable.

Rule 1300.74.72(f)
A health plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set for in Health and Safety Code section 1374.7.

B. UTILIZATION MANAGEMENT

Deficiency 2: For benefit denials, the Plan does not clearly describe in the denial letter the provisions in the Evidence of Coverage that exclude coverage of the requested service. [Section 1367.01(h)(4)]

Citation:
Section 1367.01(h)(4)
Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding clinical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan.

A P P E N D I X F

LIST OF ACRONYMS

Acronyms	Definition
CAP	Corrective Action Plan
DMH	Department of Mental Health
DOI	Department of Insurance
EAP	Employee Assistance Program
ECT	Electroconvulsive Therapy
EOC	Evidence of Coverage
ER	Emergency Room
HMO	Health Maintenance Organization
LCSW	Licensed Clinical Social Worker
LOCAT	Level of Care Assessment Tool
MFT	Marriage and Family Therapist
PCP	Primary Care Physician
Psy.D.	Doctor of Psychology
SOC	Summary of Coverage
TRF	Treatment Request Form
UM	Utilization Management

A P P E N D I X G

THE SURVEY PROCESS AND INSTRUCTIONS FOR THE PLAN'S CORRECTIVE ACTIONS AND RESPONSES

The following provides detail on the required survey activities and the order in which they are undertaken by the Department as well as instructions on how plans must institute corrective actions and prepare their responses to the Preliminary Report and the Final Report. Table 10 summarizes the survey activities and the corresponding timeframes.

TABLE 10: FOCUSED SURVEY PROCESS

SURVEY ACTIVITY	TIMEFRAME
Focused Survey On-Site Visit Conducted	As needed
Preliminary Report due from the Department to the Plan	30 – 50 calendar days from the last day of the on-site visit
Response due from Plan to the Department [Section 1380(h)(2)] *(Include evidence that each deficiency has been fully corrected)*	45 calendar days from date of receipt of Focused Survey Preliminary Report
Final Report due from the Department to the Plan	Within 170 days from the last day of the on-site visit
Response from Plan to Department on any matters in Final Report	Within 10 calendar days from receipt of Final Report. Response is included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the on-site visit

Survey Preparation

The Department conducts a Focused Survey of a licensed health care service plan on an adhoc basis in order to evaluate a plan's compliance with certain Knox-Keene requirements and address specific issues identified by the Department. This Focused Survey specifically evaluates a plan's compliance with Section 1374.72.

Prior to the visit, the Department supplies the Plan with a Pre-On-Site Visit Questionnaire and a list of materials that the Plan is required to submit to the Department prior to the on-site visit. These materials are reviewed by the survey team to provide them with an overview of plan operations, policies and procedures in preparation for the visit. The Plan is also advised of the materials (e.g., case files, reports) the surveyors will review during the on-site visit so that these will be readily available for the survey team.

On-site Visit

During the on-site visit, the survey team reviews materials and conducts interviews with Plan staff and possibly with providers.

Preliminary Report

Specific to this Mental Health Parity Focused Survey, the Department provides the Plan with a Preliminary Report within 40 days of the on-site visit. The Preliminary Report details the Department's survey findings and the required corrective actions.

Plan's Response to the Preliminary Report

In accordance with Section 1380(h)(2), the Plan has 45 calendar days from the date of receipt of the Preliminary Report to file a written response. Preliminary and Final Reports are "deficiency-based" reports; therefore, only specific areas found by the Department to be in need of improvement are included in these Reports. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance in other areas.

All deficiencies cited in the Preliminary Report require corrective actions by the Plan. The Department specifies corrective actions in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Plan must implement all required actions in the manner prescribed by the Department. The Plan must submit evidence that the required actions have been or are being implemented when the Plan submits its 45-day response.

The Plan's response should include the following information for each deficiency identified in the Preliminary Report:

(1) The Plan's response to the Department's findings of deficiencies;

(2) The Plan's response to the Department's specified corrective actions, which include a corrective action plan (CAP);

(3) Whether the CAP is fully implemented at the time of the Plan's response. If the CAP is fully implemented, the Plan should provide documents or other evidence that the deficiencies have been corrected; and

(4) If the CAP cannot be fully implemented by the time the Plan submits its response, the Plan should submit evidence that remedial action has been initiated and is on the way to achieving compliance. Please include a time-schedule for implementing the corrective action and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the Plan's response indicates that the development and implementation of corrective actions will not be completed by the time the Plan files its 45-day response, the Plan should file any policies and procedures required for implementation as Plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the Plan should file both a clean and redline version of revised policies and procedures through the Department's web portal. The Plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the web portal. The Plan is not to submit its entire response to the Preliminary Report through the Department's web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review of the Plan's response to the Preliminary Report, the Department will publish a Final Report. This report will contain the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response and the Department's determination concerning the adequacy of the Plan's response. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The Final Report will first be issued to the Plan, followed by a copy to the public file. The Final Report will be issued to the public file not more than 180 days from the conclusion of the on-site survey.

The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after the reports are issued.